RETIREE REPORT

Serving the Retired Military Community

Retiree Appreciation Day – September 10, 2005

Published by the Retiree Activities Office, Scott AFB, IL

Welcome to Retiree Appreciation Day

Welcome to the 375 Airlift Wing 20th Annual Retiree Appreciation Day - 10 September 2005. This Retiree Report Newsletter is designed first to be a program of activities for the day and to provide some general information of interest to the retired community.

The Scott Club doors will open at 7:15 a.m. for registration. Activities start at 8:00 a.m. and continue until 3:00 p.m. We were pleasantly surprised by the number of attendees last year and expect to have a great program this year. The Retiree Appreciation Day activities are designed to answer as many retiree questions as possible. Opening remarks and announcement of the Volunteer of the Year award will begin at 8:00 a.m.

This event starts with speakers and continues until 11:00 a.m., followed by lunch, then with booths from 12:30 p.m. until 3:00 p. m. (Bus transportation will be provided during the morning to the Dental Clinic, to building 509 for DOD auto stickers, and to building P-10 for ID cards and DEERS updates). Booths, staffed by organization representatives, will provide information and describe services from these organizations: Delta Dental, DFAS, Survivor Benefit Program, NAUS, MOAA, IRS, Illinois Department of Revenue, Base Exchange, Commissary, Family Support, AARP, AMVETS, Estate Planning, AF Sergeants Association, American Red Cross, Public Health, Dental, Life Skills, Family Practice, Substance Abuse, Nutritional Medicine, TRICARE, Base Library, Health, the Area Agency on Aging, Wellness Center, and many more.

Speakers will begin at 8 a.m. and continue until 11 a.m. The keynote speaker is Major General (Retired) William M. Matz, Jr. USA, Retired. MG Matz is President of the National Association for Uniformed Services (NAUS). A short briefing will be given by Legal Office, The Illinois Agency on Aging, HAWC, SWIC Programs/Services for Older Persons, AAFES, Survivor Benefit Plan (SBP), and Commissary. For those of you planning ahead, you can mark your calendar for the 9th of September 2006 for the next year's Annual Retiree Appreciation Day.

Retired Military members are one of the armed services most valuable assets, carrying and passing on the traditions and knowledge that created and maintains the world's premier military. This day is our way to say thank you for the many years of service and dedication each one of you devoted to defending and protecting the United States and our national interests. Our goal is to show you that the effort and commitment is valued - we want to demonstrate our appreciation by honoring you with an informative and productive day.

[Source Col Raymond J. Rottman, Commander, 375th Airlift Wing]

Schedule of Events
20th Annual Retiree Appreciation Day
September 10, 2005

PLACE	**HOST**
Scott Club Banquet Area	375 AW/CC

AGENDA

0715 Club doors open

0730 Continental breakfast begins

0800 Welcome
- Overview of events/schedule/shuttle
- Volunteer of Year Award for 1 Jan 04 – 31 Dec 04 – MSgt (Ret) Eugene Ryan, Director of the Scott AFB Retiree Activities Satellite Office in Rantoul, IL.
- Introduction of guest speaker by Col Rottman

0810 Guest speaker William M. Matz, Jr., Major General, US Army (Retired)

0845 Break

0900 Introduction of Briefers
- Legal Office (15 min)
- Illinois Area Agency on Aging (15 min)
- HAWC (15 min)
- SWIC Programs/Services for Older Persons (15 min)
- AAFES (15 min)
- Survivor Benefit Plan (15 min)
- Commissary (15 min)

1115 Lunch

1230 Exhibits

1445 Closing Remarks

Gen. Matz Biography

Key note Speaker, WILLIAM M. MATZ, JR. Major General (Retired), was born in Drexel Hill, Pennsylvania. Upon graduation from Gettysburg College, he was commissioned a second lieutenant and assigned to the 82nd Airborne Division. Following this initial assignment, he served along the demilitarized zone in Korea with the 1st Battalion, 8th Cavalry, 1st Cavalry Division and 2nd Battalion, 23rd Infantry, 2nd Infantry Division successively as a rifle company commander and battalion S3.

Upon his return from Korea, he was assigned to the Ranger Department, U.S. Army Infantry School. In October 1967, he arrived in Vietnam and served as a rifle company commander with the 3rd Battalion, 47th Infantry, 9th Infantry Division, in the Mekong Delta, where he was wounded in action during the 1968 Tet Offensive.

Upon return from Vietnam, he was assigned as Assistant Professor of Military Science, ROTC Department, Middlebury College, Vermont. MG Matz returned to WESTPAC in June 1970 where, as Plans/Special Operations Officer on the Afloat Staff, Amphibious Forces, Pacific Fleet, he planned and participated in amphibious operations along the Vietnam coast.

In June 1973, he was assigned to the Strategy, Plans and Policy Directorate, ODCSOPS, DA, as a strategic planner and Directorate Executive Officer until assuming command of the 3rd Battalion, 187th Infantry, 101st Airborne Division in July 1977.

In 1980, he returned to the 82nd Airborne Division and served as Division G3 from June 1980 to July 1982. Following this assignment, he returned to Korea where he served as Chief, Force Development Division, G3/J3, Eighth Army/U.S. Forces Korea Staff. In 1983, he assumed command of the 4th Training Brigade, U.S. Army Armor School. Upon relinquishing command in 1985, he returned to the Army Staff as Deputy Director, Training Directorate, ODCSOPS.

This was followed by a tour of duty as Executive Secretary to the Secretary of Defense. In August 1988, he became the ADC (S), 7th Infantry Division (Light), and deployed with the Division to Panama on Operation JUST CAUSE.

MG Matz assumed duties as the Deputy Commanding General, U.S. Army Pacific in February 1990. He then served as the Deputy Commanding General and interim Commanding General of First Corps and Fort Lewis from November 1991 until his retirement from the U.S. Army in September 1995.

MG Matz is a graduate of the Infantry Officer Basic and Advanced Courses, the Airborne and Ranger Courses, the Command and General Staff College and the Army War College. He received a BA degree in Political Science from Gettysburg College and a MA degree in Political Science from the University of San Diego. Among his awards and decorations are the Distinguished Service Cross, Defense Distinguished Service Medal, Distinguished Service Medal, Silver Star, Defense Superior Service Medal, Legion of Merit (with three Oak Leaf Clusters), Bronze Star for Valor, Purple Heart, and the Combat Infantryman Badge.

MG Matz and his wife Linda reside in Great Falls, Virginia, and are the parents of three married children.

COLON CANCER DETECTION

Cancer of the colon or rectum (Colorectal cancer) is the second leading cancer killer in the United States after lung cancer. About 135,000 new cases are diagnosed each year and 55,000 deaths occur each year.

More than one-third of colorectal cancer deaths could be avoided if people over 50 had regular screening tests. Screening tests can help prevent colorectal cancer by finding pre-cancerous polyps so they can be removed before they turn into cancer.

Most colorectal cancers begin as polyps. Polyps are growths on the inner wall of the colon or rectum. People who have polyps or colorectal cancer do not always have symptoms, especially at first. Screening tests are important because they can find colorectal cancer early, when treatment works best.

When colorectal cancer is detected in the earliest stage of the disease (Stage 1), the survival rate is 96%. The risk of developing colorectal cancer increases with age. In fact, 92% occur in people 50 and older. Both sexes may develop this cancer.

Several different screening tests can be used to test for polyps or colorectal cancer. Each can be used alone.

Sometimes they are used in combination with each other. Medicare Part B and TFL cover the following:

1. Fecal Occult Blood Test (FOBT) or Stool Test - Covered once every 12 months. You pay no coinsurance and no Part B deductible. This is a test you do at home using a test kit you get from your health care provider. You put stool samples on test cards, then return the cards to the doctor or a lab. This test checks for occult (hidden) blood in the stool.

2. Flexible Sigmoidoscopy (Flex Sig) - Covered once every 4 years. You pay 20% of the Medicare approved amount after the yearly Part B deductible. If the flexible sigmoidoscopy or colonoscopy is done in a hospital outpatient department, you pay 25% of the Medicare-approved amount after the yearly Part B deductible. This is a test in which the doctor puts a short, thin, flexible, lighted tube into your rectum. The doctor checks for polyps or cancer in the rectum and lower third of the colon. Sometimes a flexible sigmoidoscopy is used in combination with a Fecal Occult Blood Test (FOBT).

3. Colonoscopy High Risk Individuals - If you are at high risk for colorectal cancer, Medicare covers a colonoscopy or a barium enema every 2 years. You pay 20% of the Medicare approved amount after the yearly Part B deductible. Your risk for colorectal cancer may be higher than average if you or a close relative had colorectal polyps or cancer, or if you have inflammatory bowel disease.

4. Average Risk Individuals - If you are at average risk (i.e., not at high risk) for colorectal cancer, Medicare will cover a colonoscopy every 10 years. You pay 20% of the Medicare approved amount after the yearly Part B deductible. However, if you are at average risk and have had a covered flexible sigmoidoscopy, you must wait 4 years to be eligible for Medicare coverage of a colonoscopy. This test is similar to a flexible sigmoidoscopy, except the doctor uses a longer, thin, flexible, lighted tube to check for polyps or cancer in the rectum and the entire colon. During the test, the doctor can find and remove most polyps and some cancers.

5. Double Contrast Barium Enema - This test can substitute for a flexible sigmoidoscopy or for a colonoscopy. This test is covered every 24 months if you are at high risk for colorectal cancer and every 48 months if you aren't at high risk. You pay 20% of the Medicare approved amount after the yearly Part B deductible. A test in which you are given an enema with a liquid called barium. The

doctor takes x-rays of your colon. The barium allows the doctor to see the outline of your colon, to check for polyps or other abnormalities.

Colonoscopy is an effective procedure to identity and remove polyps in the colon before they become cancerous. It is often recommended if there is a change in bowel habits, unexplained chronic diarrhea, constipation, abdominal pain, blood in stools, anemia, or suspicion of colon polyps or cancer. Your colon must be clean during the procedure to give the physician clear view.

Typically, bowel prep involves drinking a gallon of a special flavored laxative solution the night before. An intravenous sedative and pain medication is given before the procedure begins. Your doctor inserts a flexible fiber-optic tube called a colonoscope into your rectum. It is about half an inch in diameter, as long as the colon, and has a micro camera at the tip. Because of the medication, it is practically painless. A small amount of air is used to expand the colon and make it easier to see the colon wall.

If polyps, other small growths, or abnormally inflamed tissue is found thy often can be removed during the procedure for further examination. A complete procedure takes about 45 minutes.

"Virtual" colonoscopies use CT scanning to get a visual image. They are faster and do not require any sedative or pain medication. However, they require the same bowel prep and involve the insertion of a tube into the rectum to blow in air to expand the colon. They are expensive and cannot identify many smaller polyps. If any are found a regular Colonoscopy is required for removal. Additional information can be found at http://www.acg.gi.org/.

[Source: Military Officer Nov 04 & MEDICARE web site http://www.medicare.gov/Health/ColonCancer.asp]

Retiree Weekend Sept 10th at Scott AF Base Club

AAFES at Scott AF Base will support a continental breakfast for the Retiree Event the morning of Sept 10th , consisting of doughnuts, orange juice and coffee. AAFES will also donate a television in support of the event and create a special flyer for shopping here at the BX. The following week, 16_18 September will be the Still Serving Event that AAFES has corporately put together to honor our retirees. A special mailing will be sent to all retirees that is full of coupons and special buys that will be offered at the Exchange.

[Source Mr. James Clark, Manager]

Choosing TRICARE Standard

TRICARE Standard is the TRICARE option that provides the most flexibility to TRICARE-eligible beneficiaries. It is the fee-for-service option that gives beneficiaries the opportunities to see any TRICARE-authorized provider. TRICARE Standard is not available to active duty service members. Standard shares most of the costs of medically necessary care from civilian providers when military treatment facility (MTF) care is unavailable.

Getting Help:

TRICARE Standard has specific rules, and beneficiaries choosing to use TRICARE Standard may need to contact the regional contractor call centers toll free number or a beneficiary counseling and assistance coordinator (BCAC) in their area for assistance. Customer service staff can answer specific questions about health care benefits, billing or claims as well as provide help navigating

through the Military Health System. Beneficiaries may locate a BCAC online at http://www.tricare.osd.mil/beneficiary/beneficiary/BCACDirectory.htm.

Reasons for Choosing TRICARE Standard:

Beneficiaries who are happy with the treatment they currently receive from a specific civilian provider that may not be in the TRICARE provider network often choose to use TRICARE Standard. Some beneficiaries, especially retirees under age 65 and their families, may live in areas where the TRICARE Prime network is not available, and TRICARE Standard may be their only option. Additionally, retired service members may have employer-sponsored health insurance. TRICARE Standard may be used as secondary coverage for these beneficiaries.

TRICARE Standard Features:

TRICARE Standard offers greater provider choice. Beneficiaries may choose any TRICARE-authorized provider. TRICARE-authorized providers are not required to participate in the TRICARE network; however, they must be certified as an authorized provider by the regional contractor in that region. Beneficiaries should contact their regional contractor to find a TRICARE-authorized provider or go online to see a list of standard providers.

TRICARE Standard allows beneficiaries to self-refer for specialty care. Beneficiaries who choose TRICARE Standard are not assigned a primary care manager, so, in most cases, they are able to see specialists without prior authorization. There are some outpatient procedures that require prior authorization. Beneficiaries should contact their regional contractor for authorization assistance before seeking care.

For inpatient mental health care, preauthorization and continued stay authorization requirements apply to Residential Treatment Center care, partial hospitalization program care, and alcoholism detoxification and rehabilitation. All beneficiaries should contact TRICARE regional contractors regarding potential limits on length-of-stay at these facilities. TRICARE Standard beneficiaries living in an MTF catchment area must obtain a non-availability statement from their local MTF before being admitted as an inpatient for mental health services.

Costs for TRICARE Standard:

Beneficiaries are responsible for cost shares and deductibles for care that is covered under TRICARE Standard. Providers who participate in TRICARE will accept the TRICARE allowable charge (TAC) as the full fee for services they render. However, non-participating providers may charge up to 15 percent above the TAC for their services, and TRICARE Standard beneficiaries are financially responsible for these additional charges.

A "catastrophic cap" is the annual upper limit a family will have to pay for TRICARE Standard-covered services in any fiscal year. The catastrophic cap for families of active duty service members is $1,000. All others have a catastrophic cap of $3,000. The catastrophic cap applies only to allowable charges for covered services. The catastrophic cap does not apply to services that are not covered, or to the total amount of what nonparticipating providers may charge above the TAC.

Annual Deductible:

$150 per individual or $300 per family, for E-5 and above. $50 per individual or $100 per family, for E-4 and below. $150 per individual or $300 per family, for Retirees, their family members and others.

Cost Share:

- Outpatient visits, emergency care and mental health visits: For family members of Active Duty Service members, 20 percent of allowable charges; Retiree, their family members and others, 25 percent of allowable charges.

- Civilian Inpatient Cost Share: For family members of Active Duty Service members, Greater of $25 or $13.90* per day; Retiree, their family members and others, Lesser of $512* per day or 25 percent of billed charges plus 25 percent of allowed separately billed professional fees.

- Civilian Inpatient Mental Health: For family members of Active Duty Service members, $20 per day; Retiree, their family members and others, Lesser of $169* per day or 25 percent of allowable fees plus 25 percent of allowed separately billed professional fees

*(*FY 2005; rates change every fiscal year - Applies to above paragraphs)*

Helpful Hints:

Sponsors should ensure their family members have up-to-date uniformed services identification cards, and that they are properly enrolled in the Defense Enrollment Eligibility Reporting System (DEERS).

- Beneficiaries may be required to file their own claims when using TRICARE Standard. Beneficiaries may find more information about filing claims and download claims forms on the TRICARE Web site at http://www.tricare.osd.mil/claims/default.htm .

- Although TRICARE Standard beneficiaries have a lower priority for access to care in MTFs than TRICARE Prime enrollees, Standard beneficiaries may attempt to receive their care from an MTF. This will save them money and paperwork.

Beneficiaries will save money by seeking care from a TRICARE network provider. For more information see TRICARE Extra.

[The TRICARE/Military Health System Web site http://www.tricare.osd.mil/claims/default.htm]

Is Our Community Ready for the Age Wave?

Later this year, Congress will have an opportunity to make sure that every community across the country has the resources it needs to prepare to meet the challenges and opportunities of the coming "age wave." Since its inception in 1965, the Older Americans Act, the guiding force behind our nation's aging services network, has evolved to meet changing needs and expectations and the time is ripe for the Act to evolve once more.

With 77 million baby boomers in the U.S., we must turn our attention to what has been called a "quiet crisis." But there's really nothing quiet about it: the aging of our population will have a tremendous impact on every community in America, no matter how big or small, including our own.

The demographics paint a vivid picture. By 2030 the population age 65 and over will more than double to over 71 million, or 20 percent of the total U.S., population. Over this same time period, the

85 and over population is projected to increase from 4.6 million to 9.6 million. In the 7 counties of Bond, Clinton, Madison, Monroe, Randolph and St. Clair the population of persons over 60 is 115,000.

The growth in our aging population will be matched by an increase in the need for local support services that enable older adults to stay in their homes and communities, in other words, to "age in place." This year marks the 40th anniversary of the Older Americans Act of 1965, which established the programs that have been the foundation of services for older adults such as home-delivered meals, assisted transportation, adult day care, and home health and personal care visits.

These services and a range of others administered by the nation's Aging Network of nearly 900 Area Agencies on Aging and Native American aging programs, play a critical role in allowing senior to age in place, but they must be enhanced as part of a broad continuum of local services and supports that allow older adults to remain in their homes and communities.

Doing so means much more than building more senior centers and congregate meal sites, or focusing exclusively on the housing needs of the aging population. Every major facet of community life comes into play, from public safety, affordable housing, accessible transportation, health and social services to education, employment, and social and cultural opportunities.

Moreover, as the baby boom generations ages our community will need top develop supports that meet their unique social ad economic needs. While 89 percent of baby boomers want to "age in place," many communities are presently ill equipped to make this a reality.

As the focal point of service delivery to Southwestern Illinois older adults the Area Agency on Aging of SW IL is well positioned to serve as a catalyst to assist our community in starting to plan for the future. But aging agencies alone cannot meet these challenges. Local elected officials, planners, service providers, civic groups and foundations, and other interested parties must join together to develop a community action plan to address the local issues that can make aging in place a reality.

As you can imagine, our growing aging population places an increased demand on local aging agencies, which too often lack sufficient resources to provide services to everyone who needs them. The Area Agency on Aging of SW IL currently has waiting lists for services like home-delivered meals and alternative transportation, and respite services that grow longer each day.

This year, as Congress addresses future policy and funding levels for the Older Americans Act, it is essential that federal policymakers increase our nation's investment in aging programs. New funding should be established to support AAAs and Title VI Native American aging programs as they help county and city governments across the nation prepare for the aging of the baby boomers.

These new funds are essential to the success of planning efforts at the local level as we seek to make every community a good place to age. For more information call 1-800-326-3221 or visit our website at www.answersonaging.com/ .

[Joy Paeth, CEO, Area Agency on Aging of SW IL Aug 05]

ATOMIC VETERANS RELIEF ACT

H.R.2962 introduced by Representative Neil Abercrombie (D-HI) will revise the eligibility criteria for presumption of service-connection of certain diseases and disabilities for veterans exposed to ionizing radiation during military service, and for other purposes.

For years atomic veterans have not received adequate consideration on their claims for exposure to ionizing radiation.

Since the 1980s, claims for Department of Veterans Affairs (VA) benefits by atomic veterans for radiogenic diseases, which are not currently on the presumptive list of diseases, have required an assessment to be made by DTRA (Defense Threat Reduction Agency) as to the nature and amount of the veteran's radiation doses.

The accuracy of the Government's radiation dose reconstruction program has been questioned and doubted for a long time.

The National Research Council's most recent review of the DTRA Dose Reconstruction Program confirmed that dose estimates have been miscalculated and often based on arbitrary assumptions resulting in grossly underestimating the actual radiation exposure. H.R. 2962 would correct injustice by revising the eligibility criteria for presumption of service connection for radiogenic diseases and remove the uncertainties related to dose quantification, often constructed years after all service records have been retired or destroyed.

Additional information is available at: capwiz.com/usdr

[Source: USDR Action alert 1 JUL 05]

The Army & Air Force Exchange Service (AAFES)

The Army & Air Force Exchange Service (AAFES) will formally honor military retirees during its annual "Still Serving" weekend, Sept. 16-18, at PXs and BXs throughout CONUS and in select stores in Europe and in the Pacific. AAFES "Still Serving" consists of a direct mail campaign to approximately 1.4 million military retirees, including information about their Exchange benefits, a variety of coupons and discounts and a sweepstakes entry card.

Throughout the "Still Serving" weekend, AAFES stores will also create excitement through special events such as drawings, free refreshments, free product samples, vendor demonstrations and door prizes.

Representing nearly half of AAFES' military households, the Exchange strives to maintain a strong relationship with retirees throughout the entire year. "Military retirees make up 42 percent of sponsors eligible to shop AAFES facilities," said Mike Westphal, senior vice president, Marketing. "While we pause to formally recognize them in September of each year, AAFES and its associates understand that retirees deserve our gratitude 365 days a year."

Every time retirees choose to shop at the exchange, they provide needed support for Morale, Welfare and Recreation (MWR) programs, facilities and non-appropriated fund construction projects

such as bowling and youth centers, golf courses and outdoor recreation. "Retiree support plays a big part in AAFES' annual dividend. Without their support it would not have been possible for AAFES to return more than $242 million to Armed Forces MWR programs last year," said Westphal.

Retirees can learn about activities planned for their Exchange by calling their local store manager. Contact information can be found online at www.aafes.com, by clicking on the "store locator" link. "AAFES' 'Still Serving' weekend will be full of great information and events," said Westphal. "I hope military retirees will make a point to stop by their local Exchange for a not-to-be-missed weekend."

The Army & Air Force Exchange Service (AAFES) is a joint command of the U.S. Army and U.S. Air Force, and is directed by a Board of Directors who is responsible to the Secretaries of the Army and the Air Force through the Service Chiefs of Staff. AAFES has the dual mission of providing authorized patrons with articles of merchandise and services and of generating non-appropriated fund earnings as a supplemental source of funding for military Morale, Welfare and Recreation (MWR) programs. To find out more about AAFES' history and mission or to view recent press releases, please visit our web site at www.aafes.com/pa/default.asp.

SURVIVOR BENEFIT PLAN (SBP)
OPEN ENROLLMENT PERIOD BEGINS OCTOBER 1, 2005

The National Defense Authorization Act for Fiscal Year 2005 providing changes to the Survivor Benefit Plan (SBP). Beginning October 1, 2005 and ending March 31, 2008, the two-tier method of computing the annuity for a spouse annuitant age 62 and older is eliminated by increasing the amount of the annuity four times during the elimination period as follows:

AMOUNT OF ANNUITY

- October 2005 through March 2006: 40 percent
- April 2006 through March 2007: 45 percent
- April 2007 through March 2008: 50 percent
- April 2008 and after: 55 percent

OPEN ENROLLMENT

The Open Enrollment Period begins October 1, 2005, and ends September 30, 2006. An eligible member is a member or former member of a Uniformed Service who, on September 30, 2005

(1) is either (a) entitled to retired pay, or (b) would be entitled to retired pay under chapter 1223 of title 10, United States Code (or chapter 67 of title 10, United States Code, as in effect before October 5, 1994), but for the fact of being under 60 years of age; **and**

(2) is not participating in SBP (or Reserve Component SBP if applicable), and was previously eligible to elect SBP or RCSBP coverage, **or**

(3) is participating in SBP (or RCSBP if applicable) at less than the maximum level for a spouse or former spouse, or is providing child-only coverage.

TWO CATEGORIES

There are two categories of elections allowed during this open enrollment period:

> **1.** A member or former member who, on September 30, 2005, is otherwise eligible, but is not participating in SBP or RCSBP, may elect SBP (or RCSBP if applicable) for any type of coverage that member or former member would have been eligible to elect and declined, or failed to elect, at an earlier opportunity.
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> **2.** A member or former member who, on September 30, 2005, is participating in SBP or RCSBP at less than the maximum level for a spouse or former spouse, or had elected child-only coverage, may elect to add coverage, up to the maximum level for a spouse or former spouse.

In case of a member or former member who had previously elected child-only coverage, the child-only coverage may be increased to an amount not to exceed the maximum base amount, or coverage for a spouse, or a former spouse who is the parent of issue of that child, at a base amount not less than the amount provided for that child-only coverage may be added. In addition, child coverage may be added to spouse or former spouse coverage previously in effect.

Members may only designate beneficiaries who satisfy the prescribed legal criteria for the category of coverage as of the date the election is filed. No open enrollment election may remove an existing beneficiary in order to provide coverage for a different beneficiary. Consistent with section 645(d), members may not elect to cover a beneficiary or select a level of coverage that could not be in effect as the result of an election previously made by the member. For example, a member who was married upon retirement may not elect insurable interest coverage.

Additionally, no elections for Supplemental SBP (SSBP) coverage may be made under this open enrollment period. Elections shall be effective the first day of the first calendar month following the date the election is received. However, no election shall have an effective date prior to October 1, 2005.

A member may cancel an open enrollment SBP election by notifying the finance center in writing within 30 days of being notified by the finance center of the effective date of the election and the amount due to participate in this open enrollment period. The finance center must receive the written notification before the end of the 30-day period starting on the date of the letter notifying the member. In addition, an RCSBP election may also be cancelled by notifying the appropriate Reserve Component Personnel Center in writing within 30 days of being notified that the RCSBP election was received. The reserve personnel center must receive the written notification before the end of the 30-day period starting on the date of the letter notifying the member.

If a member dies within two years of the effective date of the election, the election is void. All open enrollment premiums shall be refunded in a lump sum payment to the person who would have been the beneficiary had the member lived the required two years. Members must pay open enrollment premiums for elected coverage based on the number of years that have elapsed since the member's first opportunity to participate in the SBP. The number of years that have elapsed generally begins on the date of the member's first opportunity to participate in SBP or RCSBP. For most members this will be the date of retirement. However, under certain circumstances, the date may be different.

To make an election you must complete a DD Form 2656-9, Survivor Benefit Plan (SBP) and Reserve Component Survivor Benefit Plan (RCSBP) Open Enrollment Election (Public Law 108-375)

(October 1, 2005 - September 30, 2006). Elections must be submitted to the Service designated agent indicated in the instructions on DD form 2656-9. All elections must be postmarked by September 30, 2006. An electronic copy of the form is available on the Internet at: www.dtic.mil/whs/directives/infomgt/forms/eforms/dd2656-9.pdf

[If you have any questions about the SBP Open Enrollment, please call Mr. Paul Hendrix @ 618-256-6508, Scott AFB, Casualty Assistance and Survivor Benefit Plan Manager.]

DEATH GRATUITY UPDATE

The Department of Defense announced 1 JUL 05 a significant increase in the death gratuity for the survivors of service members killed in action and the Service members' Group Life Insurance (SGLI) coverage for service members deployed to designated combat zones. The Emergency Supplemental Appropriations Act for Defense, the Global War on Terror and Tsunami Relief Act 2005 (Public Law 109-13) increases this immediate cash payment from $12,420 to $100,000 for survivors of those whose death is as a result of hostile actions and occurred in a designated combat operation or combat zone or while training for combat or performing hazardous duty. The supplemental also increases the maximum amount of SGLI coverage from $250,000 to $400,000 for all service members effective 1 SEP 05 and provides that the department will pay or reimburse the premiums to service members, who are deployed in a designated combat zone for $150,000 of SGLI coverage.

Until the effective date for the SGLI increase, the supplemental provides for a special death gratuity of $150,000, retroactive to 7 OCT 01, for survivors of those whose death is in a designated combat operation or combat zone or occurred while training for combat or performing hazardous duty. The Secretary of Defense has designated all areas where service members are in receipt of the combat zone tax exclusion as qualifying combat zones and all members deployed outside the United States on orders in support of Operation Enduring Freedom or Operation Iraqi Freedom as participating in qualifying combat operations. Effective immediately, survivors of service members, who die in these qualifying zones or operations, will receive the increased benefits. The services will also identify eligible survivors of service members who died in these designated zones and operations since 7 OCT 01 and begin making the retroactive payments within a few days. The process of identifying all eligible beneficiaries and completing these retroactive payments will take several months. Survivors of members who did not die in a designated combat operation or combat zone, but were training for combat or performing hazardous duty, will also qualify for the increased benefits. Circumstances that qualify include: aerial flight, parachute duty, demolition duty, diving duty, war games, practice alerts, tactical exercises, leadership reaction courses, grenade and live fire exercises, hand-to-hand combat training, confidence and obstacle courses, accident involving a military vehicle or military weapon, exposure to toxic fumes or gas and explosion of military ordnance.

No amount of monetary compensation or level of assistance can replace a human life. However, it is our country's duty to recognize the loss of a service member with dignified and appropriate support for the family members left behind. These death benefit enhancements recognize the direct sacrifice of life of those service members placed in harm's way and in service to the nation. All beneficiaries for retroactive payments will be contacted by mail or telephone. If someone is not contacted, but thinks he may be entitled to added benefits, he may inquire at the following addresses or telephone numbers:

- **Army:** Department of the Army Casualty Operations at 1(800)626-3317.
- **Navy:** Navy Personnel Command (PERS-62), 5720 Integrity Drive, Millington, TN 38055-6200 or call 1(800) 368-3202.

- **Air Force:** Air Force Personnel Center Casualty Services Branch at AFPC/DPFCS, 550 C Street West, Suite 14, Randolph AFB TTX 78150-4216 or call 1(800) 433-0048.
- **USMC:** HQMC Casualty Office, 3280 Russell Road, Attn: MRPC, Quantico, VA 22134 or call 1(800) 847-1597.
- **USCG:** Coast Guard Personnel Services Center, 444 SE Quincy St., Topeka KS 66683-3591; Phone 785-339-3570.

[Source: DoD News Release1 JUL 05]

TRICARE - What Happens at Age 65?

Did you know that your benefits under TRICARE change at age 65? What happens at age 65? You are no longer entitled to enrollment in TRICARE Prime. I thought I would have TRICARE coverage for the rest of my life!

What do I do now?

You still have TRICARE benefits, but when you become entitled to Medicare Part A, usually at age 65, or you have a disability, or end-stage renal disease and you purchase Medicare Part B, you become eligible for TRICARE For Life (TFL).

What is TRICARE For Life?

TRICARE For Life is Medicare wrap-around coverage available to:

- Medicare-entitled uniformed service retirees, including retired guard members and reservists,
- Medicare-entitled family members and widows/widowers (dependent parents and parents-in-law are excluded),
- Medicare-entitled Congressional Medal of Honor recipients and their family members, and
- Certain Medicare-entitled un-remarried former spouses.

Remember, you must purchase Medicare Part B to receive the full benefit of TFL. Medicare will then be first pay for covered benefits and TRICARE will become second pay.

How does this happen?

Ninety days before you turn 65, DEERS will send you a letter outlining the changes in your TRICARE benefits. The Social Security Administration will notify you regarding your Medicare entitlement.

To take advantage of TFL, you and your eligible family members' personal information and Medicare Part B status must be up-to-date in the Defense Enrollment Eligibility Reporting System (DEERS). You may update your information by phone (1-800-538-9552) or by visiting your nearest ID card issuing facility. Visit http://www.dmdc.osd.mil/rsl to locate the nearest ID card facility.

How do I get additional information on this entitlement?

For TFL information you can visit the TRICARE website at www.tricare.osd.mil/ or call toll-free at 1-866-773-0404. For more information about enrolling in Medicare Part B, please visit the Social Security Administration online at http://www.ssa.gov/.

[Bruce N. Bossart, Contractor, Patient Advocate and Marketing Manager, 375th Medical Group (618) 256-7374 or DSN 576-7374 email: bruce.bossart.ctr@scott.af.mil]

The Current Status of Concurrent Receipt

Concurrent Receipt or CRDP is quite the hot topic these days. It seems there are as many interpretations of the law as there are eligible retirees. The following is a quick overview of the finer points of the law.

CRDP and retroactive Department of Veteran Affairs (VA) disability compensation awards: According to program guidance of Section 1414 of Title 10, United States Code, CRDP is not retroactive. CRDP is only payable starting the month the appropriate pay center (DFAS or Coast Guard) actually starts offsetting your VA award from your retired pay. If you are in receipt of VA compensation and for some reason the pay center did not offset your VA award, then there is nothing to restore, no concurrent
payment was made. Even if the VA withheld the difference of the award and retired pay for the prior months, CRDP is still not retroactive, if the pay center did not start the offset. If the VA did not withhold the difference, then an overpayment to the member would have resulted.

VA Unemployability Codes and CRDP:

Those members who are rated 100 percent with the VA and meet the CRDP criteria, will have their full retired pay restored effective January 1, 2005. Those members who have been rated less than 100 percent, but are receiving 100 percent from the VA due to an unemployability code, will not receive their full retired pay up front. They still fall under the 10-year phase in plan, in which they will see full restoration by the year 2014. The CRDP is paid on the actual VA rating not the unemployability code.

Chapter 61 Retirees and CRDP:

Certain individuals who retired from the military with a disability under Chapter 61 of Title 10, United States Code; will not see restoration of their full retired pay. CRDP is based on the longevity percentage, not the disability. So if your disability percentage is greater than your longevity percentage, under current policy, your CRDP will be based on the longevity percentage and will be less than your full-retired pay.

[Source: Military.com]

FINANCIAL PLANNING TIPS

Financial planning includes: reserve money in savings to keep short term emergencies from forcing you to use credit (to repair the car, etc.), insurance to provide protection from expensive, major

emergencies (with reasonable and affordable deductibles), banking techniques to save money when making investments or transferring money.

It is important to maintain an immediately available source of money for emergencies. This liquid base of income gives a cushion in order to have a financial safeguard for the unexpected. To do this, set aside one to six months of normal living expenses, depending upon your financial capability. Money market mutual funds and Series EE Savings Bonds are good places to hold this reserve. The advantage of a Series EE is that you do not pay taxes on the interest earnings until you cash the bonds. Consequently, these bonds serve as an excellent tax-deferred savings account while providing immediate liquidity when needed.

Most people need health, disability, life, auto, and home insurance. The problem is that costs can vary greatly so it is important to shop around. Take the time to examine your coverage, understand what you have and make an estimate of what you need. Then evaluate the various policies that are available, being careful to eliminate double coverage situations. These situations often occur with health insurance where the combination of TRICARE, TRICARE supplemental policies and coverage through an existing employer can lead to the payment of multiple premiums to different companies for the same coverage.

If you are military retired and have no medical insurance then TRICARE standard will meet 75% of your medical needs. There is no annual enrollment fee or premium for TRICARE standard but there is an annual deductible of $150 for an individual or $300 for a family. There is supplemental insurance that is designed to meet that 25% payment after a small deductible is paid by you. There is a premium for the supplemental insurance. Another medical coverage is TRICARE Prime. It requires an annual enrollment fee of $240 for an individual or $480 per family and has co-pay expenses. If Medicare (Part A and B) is your medical insurance, then with TRICARE-for-Life the doctor and hospital expenses are covered.
This medical insurance premium is the cost of Medicare Part B. Most medicine expenses are also met except for small co-payments like $3 for generic drugs and $9 for brand name drugs.

The majority of American workers are not covered by an employer-sponsored disability benefit program, yet statistically a 30-year old has about a 45% chance of incurring a 90-day disability before the age of 65. The lost income associated with a 3 to 6 month disability can be financially devastating. The bottom line is that if you can not afford to be out of work for 3 to 6 months, then it makes sense to get some type of disability coverage.

In some cases for auto and home insurance higher deductibles will substantially lower the cost of the insurance premium. The savings on the premium should be weighed against the likelihood of having a car accident or a household damage or theft claim in the next few years. If you change your car insurance deductible from $500 to $1,000, let's say your premium goes down $100 per year. Then, you would have to not have an accident for more than five years to actually save you money. It is something worth checking out.

The convenience offered by a credit or debit card makes it a virtual necessity in our modern society. However, the interest rates and methods of computing interest charges can make them an expensive form of borrowing. The bottom line on credit card management is to limit the number of cards you own (preferably to only one) and limit purchases to a level that permits a monthly payoff of the entire balance.

MAJOR CREDIT REPORTING BUREAUS

Stay on top of your credit history by getting a copy of your credit report and credit score. If you dispute an item, report the discrepancy in writing to the credit bureau. They have thirty days to verify the item and, if applicable, remove it from your file. The major credit reporting bureaus are:

- Equifax: www.equifax.com, 800-997-2493
- Experian: www.experian.com, 800-888-4213

- TransUnion: www.tuc.com, 888-397-3742

While the various credit bureaus use different scoring methods, the following is a reasonable indicator of your credit evaluation:

SCORE CREDIT EVALUATION

- Above 720 Very Good
- 719 - 680 Good
- 679 - 620 OK
- 619 - 585 Not Good
- 584 - 535 Poor
- Below 534 Very Bad

An ATM withdrawal is a very expensive way to get your money - a $1.50 charge on a $20 withdrawal equates to a 7.5% service charge! To eliminate these charges only use ATM machines that are located at your bank or use your debit card to get cash back from the grocery stores or drugstores. Many stores limit the amount of "cash back."

Avoid costly banker or broker fees ($20 - 50) by buying U.S. Treasury securities directly from the Government. Purchases can be make from one of the twelve Federal Reserve Banks located across the United States. If you are unsure about the location of the nearest bank, contact the Board of Governors of the Federal Reserve System in Washington, D.C. at 202-452-3000.

When moving retirement funds from one account to another, make sure that the transaction is executed as a "trustee to trustee transfer." If the funds flow through you, then the transfer may be subject to a 20%
withholding tax.

On a monthly basis most people spend their money and then save what is left. Try the reverse! When you pay your monthly bills, make the first check you write to your monthly saving account. Then pay your other
bills and use the amount left to live on for the month. This practice forces you to "buy into" your savings plan and insures that the plan actually gets funded.

The bottom line is: "Make your money work for you! You worked hard to earn it!"

[Source Excerpts from MOAA with editorial notes]

Pill and Hormone Replacement Therapy Called "Carcinogenic"

ELEANOR HALL is stressing today that Australian women should not be alarmed today by the new descriptions of the Pill and Hormone Replacement Therapy as "carcinogenic".

The World Health Organization has reviewed published scientific evidence on the pill and HRT and has toughened its classification of both to say they do cause cancer.

The WHO says the Pill slightly increases the risk of breast, cervical and liver cancer, and that HRT increases the risk of breast cancer and cancer of the uterus.

But, the Australian medical community is calling for a measured response to the reclassification, saying it's not based on any new evidence. This report from Karen Barlow.

KAREN BARLOW: Like tobacco and asbestos, the Pill and Hormone Replacement Therapy have been officially classed as cancer causing agents. The WHO's Agency for Research on Cancer made the decision after reviewing all published scientific evidence. The Agency has confirmed that combined contraceptive pills increase the risk of liver cancer, and added breast and cervical cancer to the risk list.

At the same time, the combined pill decreases the risk of cancer of the uterus and ovaries. The increasingly unpopular Hormone Replacement Therapy was also reviewed, with the Agency finding an increased risk of breast cancer, as well as cancer of the uterus. The Director of the New South Wales Breast Cancer Institute, Professor John Boyages, says the likelihood of getting cancer is still small.

JOHN BOYAGES: I think these risks are acceptable risks that in our western way of life are worth taking, particularly around oral contraceptives. And short-term use of HRT is certainly safe, based on some research we have been doing.

KAREN BARLOW: The New South Wales Breast Cancer Institute has been studying women who take Hormone Replacement Therapy. Professor John Boyages says the increase in the risk of breast cancer over five years may go up from 6.1 per cent to about 6.7 per cent.

JOHN BOYAGES: Now, for many women that less than 1 per cent increase in risk is acceptable if they're having a really terrible time with the side effects of the menopause.

KAREN BARLOW: So overall, how likely is it that a woman would get cancer from taking hormone therapies?

JOHN BOYAGES: The reality is that if you take, a look at Stadium Australia, full of 100,000 women aged 50 to 69, say. 300 out of 100,000 women would get breast cancer in one year. If all of those women, 100,000 of them were taking HRT, the risk would go up to around 450. So there's a small increase in risk. The important thing is to be sensible about how long you take it for, and have some stopping rules in place.

KAREN BARLOW: On the other side of the medical equation, these women are trying to help themselves through taking these therapies, or not become pregnant if they don't want to.

JOHN BOYAGES: Look, I think it's all about everything we do in life is taking a bit of a risk. If we decide to ride a motorbike to Brisbane without a helmet on, we take a risk, but we still may there. And we take those risks every single day. And I think a small, slight increase in risk of breast cancer, which goes away, by the way, if you stop the pill for more than 10 years, and a slight increase in risk of breast cancer from HRT may be acceptable, but the important thing is that women are aware of these risks and understand the risks and benefits.

KAREN BARLOW: The Australian Cancer Council has also questioned the severity of the cancer warning. The Council's Gillian Batt says hormone treatments can't be compared to tobacco and asbestos.

GILLIAN BATT: There's no new evidence around this. There's always been awareness that there is an increased risk, however it's nowhere near the level of asbestos.

KAREN BARLOW: Gillian Batt says women should discuss the risks and benefits of any treatment with their doctor. Australia's drug regulator, the Therapeutic Drugs Administration, agrees, and says women
should be assured the International Agency for Research on Cancer has not reclassified the hormone therapies based on any new information.

Meantime, the agency admits that more work is needed to assess hormone products.

[Source The World Today, Reporter: Karen Barlow]

Army CRSC Division August 17, 2005

The Army CRSC Division has announced that $1 billion has been awarded to retirees with disabilities across all military uniformed Services through the Combat-Related Special Compensation (CRSC) program. CRSC is a $22 billion program that provides tax-free monthly payments to injured retirees from all uniformed Services. CRSC payments are retroactive and supplement a retiree's Veteran Affairs (VA) disability pay and Service retired pay.

COL John Sackett, Army CRSC Chief, states "This is a great milestone but we have a long way to go. We hope that all eligible retirees will submit a claim. Retirees with disabilities have more than earned this compensation." $21 billion dollars is still available to approved retirees, so if you are eligible submit your claim today!

Disability Pay Programs- CRSC and CRDP

CRSC is an application-claim based program versus the Concurrent Retirement and Disability Payments (CRDP) program, which is an automatic entitlement from DFAS for any Retiree with a combined 50% or higher VA disability rating. Some Retirees believe they are already receiving CRSC when they are actually receiving CRDP and thus do not submit their claim for CRSC. If you are not certain what you are receiving, please check your DFAS pay stub and consider submitting your claim for CRSC.

It is important to note that Retirees cannot receive both CRSC and CRDP and must elect one each year through an annual "program election." Many retirees are confused about which is better for them.

When making this decision, please note the following characteristics of CRSC and CRDP:

2005 Example	**CRSC**	**CRDP**
Full Concurrent Receipt	Yes	No-10 yr phase in except 100% disability
Payment at 50% combined rating	$663	$153
VA rating starts at	10%	50%
Compensation Retroactive	No	Retroactive
Taxable	Tax	Free Taxable
Individual Unemployment (IU)	Yes	No
Survivor Benefit	No	NO
File Clam	Yes	No-Automatic
Qualified injury	Combat Linked	Service Connected

ARE YOU ELIGIBLE?

Eligible claimants are/ have:

- Retired with 20 yrs Active or Reserve Duty;
- Receiving retired pay;
- Retired pay must be offset by VA payments;
- A 10%+ disability rating; and
- At least one combat-related disability. Combat-related criteria include those VA rated disabilities that occurred under the following situations:
- In the performance of duty under conditions simulating war (e.g., named exercises, routine field training exercises)
- While engaged in hazardous service (e.g. flight, diving, parachute duty)
- Through an instrumentality of war (e.g. combat vehicles, weapons)
- As a direct result of armed conflict (e.g. Purple Heart)

OR

- Presumptive cases (e.g. Agent Orange, radiation exposure, Post Traumatic Stress Disorder)

Eligible retirees should submit their claim today!

For more information or to receive a claim form, call CRSC toll free at 1-866-281-3254 Monday through Friday from 0800-1900 hours (EST). Retirees can submit a claim online or download our CRSC claim form or www.crsc.army.mil.

[Source Military.com]

Armed Forces Vacation Club Adds Getaways

The Armed Forces Vacation Club (AFVC), a vacation rental program offered to military personnel by RCI (Resort Condominiums International, LLC), has added the option of nightly rental opportunities as an expanded service to eligible participants. Active duty and retired military personnel now have the option to rent a vacation condo either in seven day increments or choose to stay for one night or more, subject to availability.

"This is part of a continuing effort to enhance our vacation club in providing military personnel with more flexibility in choosing when and where they stay," said Verlin Abbott, AFVC program director. "With more
vacation options available we expect an increase in customer satisfaction since this program will better suit many military members who may only have short periods of time available."

Resort properties are available in the United States and Canada in daily and weekly increments. Nightly Getaway rates start as low as $75 during peak season; with peak period weekly rates as low as $199. Nightly Getaway reservations must be made within 60 days of travel. Weekly rentals can be made up to 12 months in advance, based on availability.

Rentals come in a variety of sizes: one bedroom and larger condos, studios and cottages. Many of the vacation properties come with fully equipped kitchen, washer and dryer, living room, dining area, swimming pool, hot tub, fitness center and handicapped accessibility features. For Nightly Getaway reservations call 1-888-338-0970. For weekly reservations call 1-800-724-9988 or go to www.afvclub.com.

To make any AFVC reservation, members will need their AFVC installation identification number obtainable from the following offices, depending on the military installation: MWR (Moral, Welfare & Recreation), ITT (Information, Tours & Tickets or Information, Tours & Travel) and ITR (Information, Tours & Recreation).

The Armed Forces Vacation Club is a space available program offering Department of Defense affiliated personnel the opportunity to take affordable vacations at resorts. The AFVC makes this possible by utilizing available inventory at timeshare resorts.

Resort officials indicated that Shades of Green guests have exclusive access to discounted theme park tickets, reduced rates at Disney's PGA professional golf courses, Extra Magic Hours at the parks, and much more. To book one of the End of Summer Specials, call the Shades of Green Reservations Monday through Friday from 8:30 to 5 p.m. eastern at (888) 593-2242. More information is available at
www.shadesofgreen.org/funandsun.htm

[Source Excerpts from AFRN 6 Jul 05]

Examples of Calculating SBP Open-Season Rates and Buy-In Factors

SBP Open Season Examples

SBP Spouse Only - Retired 2 years ago

* Did not elect SBP at retirement
* Retired as a LTC
* Elects full retirement pay ($3,249.99) as Annuity Base Amount
* Prospective Monthly Payment = $211.25
  (6.5% x Annuity Base Amount)
  (.065 x $3,249.99 = $211.25)
* Open Enrollment Lump Sum Buy-In Premium = $12,041.25
  (Spouse Only Lump Sum Factor (table 1) x Prospective Monthly Payment)
  (57 x $211.25 = $12,041.25)

SBP Spouse Only - Retired 5 years ago

* Did not elect SBP at retirement
* Retired as a LTC
* Elects full retirement pay ($3,016.91) as Annuity Base Amount
* Prospective Monthly Payment = $196.10
  (6.5% x Annuity Base Amount)
  (.065 x $3,016.91 = $196.10)
* Open Enrollment Lump Sum Buy-In Premium = $16,276.30
  (Spouse Only Lump Sum Factor (table 1) x Prospective Monthly Payment)
  (83 x $196.10 = $16,276.30)

SBP Spouse Only - Retired 10 years ago

* Did not elect SBP at retirement
* Retired as a LTC
* Elects full retirement pay ($2,965.91) as Annuity Base Amount
* Prospective Monthly Payment = $192.78
  (6.5% x Annuity Base Amount)
  (.065 x $2,965.91 = $192.78)
* Open Enrollment Lump Sum Buy-In Premium = $29,495.34
  (Spouse Only Lump Sum Factor (table 1) x Prospective Monthly Payment)
  (153 x $192.78 = $29,495.34)

SBP Spouse Only - Retired 15 years ago

* Did not elect SBP at retirement
* Retired as a LTC
* Elects full retirement pay ($3,063.29) as Annuity Base Amount
* Prospective Monthly Payment = $199.11
  (6.5% x Annuity Base Amount)
  (.065 x $3,063.29 = $199.11)
* Open Enrollment Lump Sum Buy-In Premium = $49,378.28
  (Spouse Only Lump Sum Factor (table 1) x Prospective Monthly Payment)
  (248 x $199.11 = $49,378.28)

SBP Spouse Only - Retired 10 years ago

* Elected $1000 as Annuity Base Amount at retirement
* Retired as a LTC
* Elects to increase to full retirement pay ($2,965.91) as Annuity Base Amount
* Prospective Monthly Payment = $192.78
  (6.5% x Annuity Base Amount)
  (.065 x $2,965.91 = $192.78)
* Open Enrollment Lump Sum Buy-In Premium = $19,550.34
  (Spouse Only Lump Sum Factor (table 1) x (Prospective Monthly Payment - Old Premium Amount)
  (153 x ($192.78 - $65.00) = $19,550.34)

SBP Spouse and Child - Retired 5 years ago

* Did not elect SBP at retirement
* Retired at age 50 as a LTC with a spouse age 47 and child age 10
* Elects full retirement pay ($3,016.91) as Annuity Base Amount
* Prospective Monthly Payment = $197.07
  (6.5% + Child Factor (table 6) x Annuity Base Amount)
  (.065 + .00032 x $3,016.91 = $197.07)
* Open Enrollment Lump Sum Buy-In Premium = $16,356.81
  (Spouse Only Lump Sum Factor (table 1) x Prospective Monthly Payment)
  (83 x $197.07 = $16,356.81)

SBP Child Only - Retired 5 years ago

* Did not elect SBP at retirement
* Retired at age 50 as a LTC and child age 10
* Elects full retirement pay ($3,016.91) as Annuity Base Amount
* Prospective Monthly Payment = $40.43
  (Child Factor (table 2) x Annuity Base Amount)
  (.0134 x $3,016.91= $40.43)
* Open Enrollment Lump Sum Buy-In Premium = $1,291.94
  (.1 x the minimum of either 10 or Years Sense Event x Open Enrollment Child Only Buy-In Factor (Table 5) x Prospective Monthly Payment)
  (.1 x 5 x 63.91 x $40.43 = $1,291.94)

SBP Insurable Interest - Retired 10 years ago

* Did not elect SBP at retirement
* Insurable Interest 5 years younger
* Elects full retirement pay ($2,965.91) as Annuity Base Amount
* Prospective Monthly Payment = $444.89
  (.1 x .05 x Age Different Factor (year's younger/5) x Annuity Base Amount)
  (.1 + (.05 x 1) x 2,965.91 = $444.89
* Open Enrollment Lump Sum Buy-In Premium = $68,068.17

(Years Sense Retirement x Insurable Interest SBP Lump Sum Factor (table 1) x Prospective Monthly Payment)
(10 x 153 x $444.89 = $68,068.17)

[Source MOAA]

Medicare Adopts EHR

How would you reinvent part of the software industry? Back in March, I suggested that Medicare could break the logjam in electronic health records (EHR) by requiring EHR for all doctors who do business with it; much like Wal-Mart is forcing its suppliers to adopt RFID.

This month, Medicare is doing something even more dramatic: It's giving away free EHR software that's customized for private medical practices. In a single stroke, Medicare is setting de facto standards for EHR and making EHR more affordable. And shaking up the whole EHR software business in the process. If you've been following the non-progress of EHR, you already know that individual doctors are the ones who haven't converted patient health records from paper to computerized systems. Hospitals
have made the transition over the past decade, spurred by laws such as HIPAA. But doctors in private practice have dragged their feet, mainly grumbling about cost. And at a typical price tag of $20,000 per doctor for commercial EHR systems, that's no surprise.

Medicare's solution? Take an existing EHR system called VistA, scale it down and make it easier to install, then rename it VistA-Office EHR and give it away to anyone who wants it. But wait, you ask, where does Medicare get off giving away free software and undercutting EHR vendors? And where did Medicare get this software it's giving away, anyhow?

Hang on -- this gets complicated. VistA comes from the Department of Veterans Affairs, which developed it in 1996 and has been running VA health care facilities with it ever since. And VistA is actually just the client/server version of the VA's Decentralized Hospital Computer Program, which the agency has been using since 1985 in 1,300 VA facilities to maintain health records of 5 million veterans. That's what we call "mature." And because it's software developed with taxpayer dollars, it's in the public domain. Anyone can get a copy of VistA under the Freedom of Information Act and then make as many copies as he likes. It's sort of like open-source software, but without any open-source license. Wait,
there's more. VistA was built on a database engine named MUMPS (now called just M). VistA is free, but M requires a license fee. VistA has also been rewritten as an open-source version called OpenVista, which runs on Linux and uses its own open-source version of MUMPS, so there's no license fee.
Medicare's VistA-Office is also in the public domain, requires M and runs on Windows. That's what doctors can get their hands on starting this month. They'll have to pay license fees for M and a few other modules, but that's only about one-tenth of the cost of a commercial EHR license.

So, what about commercial EHR vendors? They haven't actually lost any sales, since the 70% of medical practices without EHR weren't buying the high-priced spread anyway. But because VistA-Office is public domain software, commercial vendors can get it free, enhance it, copyright their improvements, then sell it for whatever price the market will bear, creating their own low-end proprietary products. And they can tweak their high-end products to make sure they'll interoperate with VistA-based EHR. Result: Instead of pricey incompatibility, we could end up just a few years from now with public domain, open-source, and low- and high-end proprietary EHR products that all work together -- and a lot more doctors using EHR. Of course, that's what the Medicare people have in mind -- to get doctors to use EHR. They're not trying to reinvent the EHR software business.

[Source: Medicare URL]

STATISTICAL ANALYSIS OF THE MILITARY EXPENDITURES

(***$*** *Shown in* ***B****illions)*

DoD + VA Expenditures vs. Gross Domestic Product

When compared to the value of all goods produced in the United States, DoD & VA expenditures are manageable. The comparisons are shown below.

The Gross Domestic Product

2005	12,227.4 est.	1980	2,726.7
2004	11,552.8	1975	1,560.7
2003	10,838.8	1970	1,012.2
2002	10,389.2	1965	687.1
2001	10,057.9	1960	517.9
2000	9,709.8	1955	394.6
1995	7,325.8	1950	273.0
1990	5,735.4	1945	221.4
1985	4,141.5	1940	96.8

The Federal Tax Dollar - Where it Goes

Category	*FY 2006 est.*	*FY 2005*	*FY 2000*
Direct Payments to Individuals	1,518.5	1,423.6	1,014.6
Non-Defense - (Discretionary)	268.6	282.4	193.8
Net Interest (National Debt)	211.1	177.9	222.9
National Defense	515.8	534.0	341.6
Other - Mandatory	123.5	126.4	58.7
All others (Adjustments)	-69.8	- 65.0	-42.6
Totals	2,567.6	2,479.4	1,789.1

The Federal Tax Dollar (Receipts) - Where it Comes From

Category	*FY 2006 est*	*FY 2005*	*FY 2000*
Individual Income Taxes	966.9	893.7	1,004.5
Social Security Receipts	818.8	773.7	652.9
Corporate Income Taxes	220.3	226.5	207.3
Excise Taxes	75.6	74.0	68.9
Borrowing			
Other	96.0	84.9	91.8
Totals	2,177.6	2,052.8	2,025.2

Total Federal, DoD and VA Expenditures

Year	*Federal Outlays*	*DoD Portion*	*VA Portion*	*Combined DoD & VA/%*
2005	2,479.4	465.9	68.2	21.5%
2004	2,292.2	456.0	59.8	22.5%
2000	1,789.1	294.5	47.1	19.1%
1995	1,515.8	272.1	37.9	20.4%
1990	1,253.1	299.3	29.1	26.2%
1985	946.4	252.7	26.3	29.5%
1980	590.9	134.0	21.2	26.3%
1975	332.3	86.5	16.6	31.0%
1970	195.7	81.7	8.7	46.2%
1965	118.2	50.6	5.7	47.6%
1960	92.2	48.1	5.4	58.0%
1955	68.4	42.7	4.7	69.3%
1950	42.6	13.7	8.8	52.8%
1945	92.7	83.0	0.1	89.6%
1940	9.5	1.7	0.6	24.2%

Notes: Data researched, courtesy Reference Department, O'Fallon Public Library Historical Tables - OMB, Budget of the United States Government, FY 2006

(DoD +VA) % of GDP

Year	%
2005	4.4*
2004	4.5
2003	4.3
2002	3.8
2001	3.5
2000	3.5
1995	4.2
1990	5.7
1985	6.7
1980	5.7
1975	6.6
1970	8.9
1965	8.2
1960	10.3
1955	12.0
1950	8.2
1945	37.5
1940	2.4

Notes: Column 2 is the % of the Gross Domestic Product (GDP) spent by DoD and VA combined.
** = Estimated.*

[Source: Scott AFB RAO 7/05]

Retiree News Briefs

2006 COLA May Be Largest in 14 Years

Earlier this week, the Bureau of Labor Statistics reported that inflation broke out of its summer doldrums with a half-point jump in July. So far this fiscal year, the Consumer Price Index (CPI) has risen 3.2%. The 2006 COLA will be determined by dividing the three-month average CPI for July, August and September 2005 by the average CPI for the same three months of 2004. Even if inflation is flat for the remaining two
months, that would make the 2006 cost-of-living adjustment (COLA) the largest retirees have seen since the 3.5% 2001 COLA, and the second-largest since the 3.7% COLA in 1992. While some may like the bigger retired pay increase, that only means that living expenses already have gone up more rapidly than usual, and retired pay, Social Security, SBP and other annuities are only chasing those expenses after the fact. Given a choice, we'd prefer lower inflation and the resultant lower COLAs. Check out the month-by-month inflation track and historical CPI/COLA information on MOAA's Web site at moaaonline.org/ct/UdzmiL41lmv/.

[Source: MOAA Leg Update 19 Aug 05]

A Place of Remembrance and Hope for the Future

The Pentagon Memorial was built as a lasting tribute to victims and to provide a place of remembrance, comfort, and reflection for those left behind. It also will serve as a place of hope and renewal for future
generations. Go to: http://moaaonline.org/ct/X1zmiL41XXvi/

[Source MOAA News Exchange 27 Jul 05]

New Flag-Folding Script

Air Force leaders recently approved a new script that can be read during flag-folding ceremonies. Though there are no official ceremonies in the Air Force that require a script to be read when a flag is folded, unofficial ceremonies such as retirements often do. More information is available at: http://www.af.mil/news/story.asp?storyID=123011364

[Source AFA Newsletter 26 Aug 05]

myPay for Retirees

The Defense Finance and Accounting Service is gearing up another effort to move more retirees into the myPay electronic system. DFAS officials will send out a letter soon to some 400,000 retired members under age 65 who are not currently enrolled in myPay. The letter focuses on the benefits of the myPay system, which is designed to help customers better manage their retired pay account. The myPay website is at https://mypay.dfas.mil. At the website, retired members can view their account information from any computer with Internet access virtually 24 hours a day, seven days a week. Anyone needing assistance using myPay, call toll free 1-800-390-2348; commercial (216) 522-5122 from 7:00 a.m.
to 7:30 p.m. (Eastern Time).

More Contracts to Disabled Veterans

While emphasizing DoD's interest in awarding more contracts to service-disabled veterans, Ramos stressed that "there's no guarantee that just because you're a disabled veteran, that you'll get a contract." Whether they're bidding on a contract to build a roadway, refurbish a building, provide computer consulting or deliver another service or product, they have to be able to meet a specific need in a professional manner, Ramos said. "You must bring forward a solution and some competency to it," he
said. "Whatever you produce for the department must be the best. There is no room for mediocrity."

More information is posted on the Small Business Administration and DoD Office of Small and Disadvantaged Business Utilization Web sites.

Related Sites:

DoD Office of Small and Disadvantaged Business Utilization
http://www.acq.osd.mil/sadbu/programs/veterans/index.htm

Small Business Administration http://www.sba.gov/

[Source Excerpts, By Donna Miles, American Forces Press Service/MBell Jul 05]

Schools Need Tutors

Schools across the country are in need of volunteer tutors. Put your experience to work. Add purpose to your life. Volunteer your time and help local children get a better start in life. I am the Illinois Tutoring
Coordinator and the schools are in great need of volunteers to tutor the children. Your assistance in getting the word out is greatly appreciated. Thanks. De Harris

[Source: Deatra Harris, dsh2766@yahoo.com, 5 Aug 2005]

Patient Management System Continues Expansion

The new Department of Defense's (DoD) electronic health records (EHR) system is now operational in 46 military medical facilities in the United States and Europe. More than 80 percent of the records have been transferred into the new system. By 2006, all Army, Navy and Air Force medical professionals worldwide will use the system to manage patients' health care and information throughout all DoD medical facilities.

Upon full deployment, nearly 60,000 military health care providers within the United States and 11 other countries will use the EHR system to gain immediate access to patients' medical history through a secured, central depository.

"Imagine-no lost records, no illegible records, no expensive or painful diagnostic tests being re-run because the data is unavailable-only comprehensive clinical information available to support well-grounded clinical decision making-that is our new reality," said TRICARE Management Activity's Army Col. Vic Eilenfield, program manager for the project.

Several of DoD's largest medical facilities will soon launch training programs to familiarize their medical staffs with the systems' capabilities. These include: Walter Reed Army Medical Center,

Washington, D.C.; National Naval Medical Center, Bethesda, Md.; and Wilford Hall Medical Center, Lackland Air Force Base, San Antonio, Texas.

Army Lt. Col. Ron Moody, MD, project officer for the Army's deployment of the system, said providers can see and document their patient's care more efficiently. Recently, health care providers in 18 Army hospitals documented more than 100,000 health care visits in one week.

"The number of patient encounters performed each week using the new system is incredible," he said. "Now-just four weeks later-the total is over 114,000 encounters per week and growing."

Air Force Col. June Carraher, MD, a family practice physician at the medical facility at Langley Air Force Base, Va., uses the system to manage the care of her patients and reports they are more than pleased with the results.

"My patients, who've had laboratory tests, x-rays, or consults at the other hospitals in the region, like Naval Medical Center Portsmouth or McDonald Army Community Hospital at Fort Eustis, are thrilled that I can immediately find their results," said Carraher, who is also the director of the new system's implementation and training program at Langley. "As a result, the medical technicians working with me are spending more time helping with care delivery and much less time making calls trying to get results from other hospitals and clinics."

[Source: TMA News Release 26 Aug 2005]

Family Members and Survivors Over Age 75 Receive Permanent Identification Cards

A permanent United States Uniformed Services Identification (ID) card will be available September 2005 for all eligible Uniformed Services family members and survivors of deceased personnel, who are age 75 and over. Currently, Uniformed Services retirees are the only persons who receive a permanent ID card.

Beneficiaries currently in possession of a valid ID card should obtain the new permanent ID card within 90 days of expiration. If beneficiaries' cards are not due to expire for at least another year, they do not need to apply for the new ID card until their existing card is within 90 days of expiring.

The Military Health System requires all eligible beneficiaries to have an ID card in order to receive health care. Beneficiaries will continue to receive health care benefits and their claims will be processed with their current ID card until they receive the permanent ID card as long as their personal information is current in the Defense Enrollment Eligibility Reporting System (DEERS).

Even though active duty and retired service members are automatically registered in DEERS, their family members are not. It is the sponsors' responsibility to register their family members into DEERS. Sponsors must also make any necessary updates in DEERS for themselves and their family members to ensure TRICARE benefits and claims processing will continue without interruption. Changes to sponsor's status, home address and family status (marriage, divorce, birth and adoption) are examples of information that needs to be properly maintained in DEERS.

It is important for surviving family members to update their personal information in DEERS when the active duty or retired sponsor dies. The DEERS Support Office can be reached by telephone at 1-800-538-9552, or information can be found online at http://www.tricare.osd.mil/DEERS .

For more information about the permanent retiree ID card or DEERS enrollment, beneficiaries may visit the TRICARE Web site at http://www.tricare.osd.mil/deers or call the TRICARE Regional Office (TRO) North (1-877-874-2273), the TRO South (1-800-444-5445), or TRO West (1-888-874-9378). Overseas beneficiaries can call 1-888-777-8343. Beneficiaries can also find the nearest ID card issuing facility at http://www.dmdc.osd.mil/rsl/owa/home.

[TMA News Release 25 Aug 05]

Note: It is anticipated these cards will be available at Scott AF Base in time for the Retiree Appreciation Day activities - if not, then shortly thereafter. For further information call RAO 618-256-5092.

DoD Seeks More Business With Service-Disabled Vets

Veterans with service-related disabilities looking for business opportunities need look no farther than the U.S. government -- and more specifically, the Defense Department. DoD, the federal government's biggest buyer of goods and services, is working to dramatically boost the contracts it awards to small businesses owned by service-disabled veterans, according to the defense secretary's chief advocate for small business affairs. DoD currently awards about $500 million in contracts every year to businesses owned and operated by veterans with service-related disabilities, Frank Ramos said today during an interview with the Pentagon Channel and the American Forces Press Service. But the goal is to increase that amount more than tenfold -- to $6 billion-within the next five years, Ramos said.

That would bring the Defense Department in line with a law that requires all federal agencies to award at least 3 percent of their procurement dollars to small business owned and operated by service-disabled veterans. President Bush issued a presidential executive order last October requiring all agencies to develop a strategic plan to put the legislation into effect. Boosting contracting opportunities for service-disabled veterans reflects the nation's recognition of their service and sacrifices, Ramos said.

To help get the word out to service-disabled veterans about business opportunities with the Defense Department, the DoD Office of Small and Disadvantaged Business Utilization is conducting an extensive outreach and education program. They've teamed up with the Small Business Administration and launched a Web site to help educate service-disabled veteran-owned businesses about government contracting and subcontracting opportunities. In addition, they're encouraging business owners to join the Central Contractor Registry, used to award DoD contracts and subcontracts.

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